State of California Department of Consumer Affairs

PHYSICIAN ASSISTANT COMMITTEE
MEDICAL BOARD OF CALIFORNIA
1424 Howe Avenue, Suite 35, Sacramento, CA 95825
Telephone: (916) 561-8780 FAX: (916) 263-2671
CALIFORNIA RELAY SERVICE BY TDD: 1-800-735-2929
E-mail: pacommittee@medbd.ca.gov

INSTRUCTIONS
TO APPLICANTS SEEKING APPROVAL TO BE A CALIFORNIA-APPROVED PA TRAINING PROGRAM

PROCESSING FEES (nonrefundable)

- Application - $5.00
- Approval - $5.00

Please send completed application and the application fee. Make check or money order payable to the Physician Assistant Committee.

PROCEDURE

Upon receipt of your application and processing fee, the licensing technician will review and present the application to the executive officer for consideration. Your training program will be advised of the status of the application after review. Upon approval you will be requested to send in the required approval fee.

If you have any questions or need assistance with completing the forms, please contact Roni Hoss, Licensing Technician, at (916) 561-8780 ext. 3, or by email at rhoss@medbd.ca.gov. If you would like a current and complete copy of California Laws & Regulations relating to the practice of Physician Assistants, they are available on our website at www.physicianassistant.ca.gov

State of California Department of Consumer Affairs

PHYSICIAN ASSISTANT COMMITTEE
MEDICAL BOARD OF CALIFORNIA
1424 Howe Avenue, Suite 35, Sacramento, CA 95825
Telephone: (916) 561-8780 FAX: (916) 263-2671
CALIFORNIA RELAY SERVICE BY TDD: 1-800-735-2929
E-mail: pacommittee@medbd.ca.gov

PHYSICIAN ASSISTANT TRAINING PROGRAM APPLICATION

FOR COMMITTEE USE ONLY
PGM _____
DATE APPROVED: _____

Please type or print clearly

PROGRAM NAME:			
MAILING ADDRESS:		*Number & Street*	
City	*State*	*Zip code*	*TELEPHONE: ( )* *FAX: ( )*
Email:			*Web Address:* *www.*

PROGRAM DIRECTOR:			
MEDICAL DIRECTOR:			
ASSOCIATED EDUCATIONAL INSTITUTION:			
MAILING ADDRESS:		*Number & Street*	
City	*State*	*Zip code*	*TELEPHONE: ( )* *FAX: ( )*

ACCREDITING AGENCY:		
CATEGORY OR LIMIT: *(full, provisional, etc.)*	*DATE OF ACCREDITATION:*	*EXPIRATION DATE:*

PHYSICIAN ASSISTANT COMMITTEE
MEDICAL BOARD OF CALIFORNIA
1424 Howe Avenue, Suite 35, Sacramento, CA 95825
Telephone: (916) 561-8780 FAX: (916) 263-2671
CALIFORNIA RELAY SERVICE BY TDD: 1-800-735-2929
E-mail: pacommittee@medbd.ca.gov
Website: www.physicianassistant.ca.gov

PHYSICIAN ASSISTANT TRAINING PROGRAM
SELF-CERTIFICATION OF COMPLIANCE FOR A CALIFORNIA-APPROVED PROGRAM

I, _____*, Program Director, of the*
(printed name of program director)

_____,
(printed name of PA training program)

certify that this program meets the requirements to become a California-approved physician assistant training program as set forth in the California Code of Regulations, Title 16, Article 3, Sections 1399.530 to 1399.539.

I declare under penalty of perjury under the laws of the State of California, that the foregoing is true and correct.

_____ _____
(signature of program director) *(date)*

SELFCERTTPA2
REV 1/03

TPA-2